# *Alabama State Board of Respiratory Therapy*

*P.O. Box 241386, Montgomery, AL 36124-1386*
*Phone: 334-396-2332 Fax: 334-396-2384*
*Web Site: www.asbrt.alabama.gov*


## *VERFICATION OF ELIGIBLITY for RESPIRATORY LICENSE by EMPLOYMENT OR WORK EXPERIENCE*

***Under Section 34-27B-7-d2, Code of Alabama (1975)***

_____
Name of Institution

_____
Street

_____

_____
City State Zip

I, _____, have applied for a license to practice respiratory therapy in the state of Alabama.
(Applicant's Full Name)

As part of the process, the Alabama State Board of Respiratory Therapy requires verification from my employer and medical director, or other physician, regarding my employment status between September 15, 2004 and September 14, 2005.

I hereby authorize _____, its staff, or representatives to provide the Alabama State
(Name of Facility)
Board of Respiratory Therapy any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the **Alabama State Board of Respiratory Therapy, P. O. Box 241386, Montgomery, AL 36124-1386**. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Alabama State Board of Respiratory Therapy office.

Sincerely,

_____ _____ _____-_____-_____
Signature of Applicant Date Social Security Number

_____ _____
Printed Name of Applicant Date of Birth

The following section must be completed by the department director, or other supervisory person, **and** physician then returned directly to the Alabama State Board of Respiratory Therapy. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. Falsifying information on this form is a violation of state law. BOTH parties must sign the form.

I, _____, _____ state that the above named individual was employed at our
(PRINT CLEARLY) Name of Department Director or Supervisor Credential (RRT, CRT, RN)

hospital/facility/agency from _____ thru _____ to provide respiratory therapy under my direct supervision as defined in the Respiratory Therapy Law (34-27B-7).

_____,_____ _____
Signature of Department Director Title Date

Phone (_____) _____-_____ Fax (_____)_____-_____ Email : _____@_____.-_____

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I, _____, licensed to practice medicine in Alabama, testify that any respiratory
(PRINT CLEARLY) Name of Medical Director or other physician

therapy performed by this individual has been under the direction of a physician to include written or verbal orders, prescription, formal medical direction, or medically approved protocols.

_____,_____ _____
Signature of Physician Title Date

Alabama Medical License # _____

Phone (_____) _____-_____ Fax (_____)_____-_____ Email : _____@_____._____